		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024992

Facility Name: FAIRVIEW NURSING CENTER

Address: 602 EAST JACKSON (Number) DUQUOIN (City) 62832 (Zip Code)

County: PERRY

Telephone Number: (618) 542-3441 **Fax #** (618) 541-6351

IDPA ID Number: 370923910001

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER W. BAGLEY **Telephone Number:** (618) 549-8331
JAMESTOWN MANAGEMENT CORP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			752	752	8
9	SNF/PED					9
10	ICF	16,142	6,446		22,588	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,142	6,446	752	23,340	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.14%

D. How many bed-hold days during this year were paid by Public Aid?
3 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/10/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 752

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	91,003	5,606	5,918	102,527		102,527		102,527			1
2	Food Purchase		71,127		71,127	4,370	75,497	(203)	75,294			2
3	Housekeeping	62,342	6,464		68,806	(258)	68,548		68,548			3
4	Laundry	44,689	6,784		51,473		51,473		51,473			4
5	Heat and Other Utilities			45,542	45,542	331	45,873		45,873			5
6	Maintenance	21,702	11,407	19,157	52,266		52,266		52,266			6
7	Other (specify):*											7
8	**TOTAL General Services**	219,736	101,388	70,617	391,741	4,443	396,184	(203)	395,981			8
	B. Health Care and Programs											
9	Medical Director			900	900		900		900			9
10	Nursing and Medical Records	579,728	16,838	69,773	666,339	(2,859)	663,480		663,480			10
10a	Therapy	23,946		3,313	27,259		27,259		27,259			10a
11	Activities	30,752	6,788	2,160	39,700	(2,985)	36,715	(2,132)	34,583			11
12	Social Services	21,245		2,160	23,405		23,405		23,405			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	655,671	23,626	78,306	757,603	(5,844)	751,759	(2,132)	749,627			16
	C. General Administration											
17	Administrative	52,202		6,684	58,886	46,542	105,428		105,428			17
18	Directors Fees											18
19	Professional Services			140,162	140,162	(81,373)	58,789	(52,799)	5,990			19
20	Dues, Fees, Subscriptions & Promotions			7,927	7,927	180	8,107	(2,435)	5,672			20
21	Clerical & General Office Expenses	22,756	6,144	8,062	36,962	16,940	53,902	(326)	53,576			21
22	Employee Benefits & Payroll Taxes			158,077	158,077	10,296	168,373		168,373			22
23	Inservice Training & Education			366	366		366		366			23
24	Travel and Seminar			2,633	2,633	209	2,842		2,842			24
25	Other Admin. Staff Transportation					1,257	1,257		1,257			25
26	Insurance-Prop.Liab.Malpractice			41,470	41,470	1,180	42,650		42,650			26
27	Other (specify):*											27
28	**TOTAL General Administration**	74,958	6,144	365,381	446,483	(4,769)	441,714	(55,560)	386,154			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	950,365	131,158	514,304	1,595,827	(6,170)	1,589,657	(57,895)	1,531,762			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FAIRVIEW NURSING CENTER #0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			26,997	26,997	2,118	29,115	35,016	64,131			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,326	3,326		3,326	22,691	26,017			32
33	Real Estate Taxes			15,087	15,087	480	15,567		15,567			33
34	Rent-Facility & Grounds			44,828	44,828	3,572	48,400	(44,828)	3,572			34
35	Rent-Equipment & Vehicles			999	999		999		999			35
36	Other (specify):*											36
37	**TOTAL Ownership**			91,237	91,237	6,170	97,407	12,879	110,286			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,820	40,940	70,760		70,760		70,760			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		29,820	82,550	112,370		112,370		112,370			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	950,365	160,978	688,091	1,799,434		1,799,434	(45,016)	1,754,418			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	23,679	30		9
10	Interest and Other Investment Income	(734)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(203)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(26)	21		18
19	Entertainment				19
20	Contributions	(300)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,619)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(516)	20		28
29	Other-Attach Schedule	(2,432)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 17,849		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(62,865)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (62,865)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (45,016)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FAIRVIEW NURSING CENTER

ID# 0024992

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DETAIL FOR LINE 29 SCH VI	$		1
2	ELIMINATE 1 YEAR OF 2 YEAR IDPH	(200)	20	2
3	LICENSE PAID IN 2003			3
4				4
5	ELIMINATE CHAMBER OF COMMERCE DUES	(100)	20	5
6				6
7	ELIMINATE ACTIVITY & CONTRIBUTION	(2,132)	11	7
8	INCOME PER INCOME RECEIVED			8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,432)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(203)	0	0	0	0	0	0	0	0	0	0	(203)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(203)	0	0	0	0	0	0	0	0	0	0	(203)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,132)	0	0	0	0	0	0	0	0	0	0	(2,132)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,132)	0	0	0	0	0	0	0	0	0	0	(2,132)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(52,799)	0	0	0	0	0	0	0	0	0	(52,799)	19
20	Fees, Subscriptions & Promotions	(2,435)	0	0	0	0	0	0	0	0	0	0	(2,435)	20
21	Clerical & General Office Expenses	(326)	0	0	0	0	0	0	0	0	0	0	(326)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(2,761)	(52,799)	0	0	0	0	0	0	0	0	0	(55,560)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,096)	(52,799)	0	0	0	0	0	0	0	0	0	(57,895)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	23,679	11,337	0	0	0	0	0	0	0	0	0	35,016	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(734)	23,425	0	0	0	0	0	0	0	0	0	22,691	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(44,828)	0	0	0	0	0	0	0	0	0	(44,828)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	22,945	(10,066)	0	0	0	0	0	0	0	0	0	12,879	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	17,849	(62,865)	0	0	0	0	0	0	0	0	0	(45,016)	45

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		FAIR ACRES NURSING HOME	DUQUOIN	Jamestown Mgmt	CARBONDALE	MANAGEMENT
		SENIOR MANOR NURSING HOME	SPARTA	Fairivew Residential	DUQUOIN	OWNS BLDG
		CANTERBURY MANOR NURSING CENTER	WATERLOO	Center Land Trust		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	$ 134,396	JAMESTOWN MANAGEMENT CORPORATION	100.00%	$ 81,597	$ (52,799)	1
2	V	30	DEPRECIATION		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%	11,337	11,337	2
3	V	34	RENT	44,828	FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%		(44,828)	3
4	V	32	INTEREST EXPENSE		FAIRVIEW RESIDENTIAL CENTER LAND TRUST	35.60%	23,425	23,425	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 179,224			$ 116,359	$ * (62,865)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	***OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIO TO COST REPORT***								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Jamestown Management Corp
Street Address: 1001 E. Main Bldg 4a
City / State / Zip Code: Carbondale, IL 62901
Phone Number: ((618) 549-8331
Fax Number: ((618) 549-0133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	18,158		$ 5,822	$	2,457	$ 788	1
2	5	UTILITIES	HOURS OF SERVICE	18,158		2,445		2,457	331	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	11,484		343,946	343,946	1,554	46,542	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	18,158		1,652		2,457	224	4
5	20	LICENSE AND DUES	HOURS OF SERVICE	18,158		1,355		2,407	180	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	6,674		110,867	110,867	903	15,000	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	18,158		9,170		2,457	1,241	7
8	22	EMPLOYEE BENEFITS	HOURS OF SERVICE	18,158		62,630		2,457	8,475	8
9	24	SEMINARS	HOURS OF SERVICE	11,484		1,546		1,554	209	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	11,484		9,288		1,554	1,257	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158		8,724		2,457	1,180	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158		15,654		2,457	2,118	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	18,158		3,545		2,457	480	13
14	34	RENT	HOURS OF SERVICE	18,158		26,400		2,457	3,572	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 603,044	$ 454,813		$ 81,597	25

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BANTERRA BANK		X	FINANCE CONSTRUCTION	$2,666.00	03-01-99	$ 310,000	$ 273,123	03-01-04	0.0825	$ 23,425	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANTERRA BANK			REVOLVING LINE OF						0.0550	3,326	6
7				CREDIT FOR OPERATING								7
8				FUNDS								8
9	TOTAL Facility Related				$2,666.00		$ 310,000	$ 273,123			$ 26,751	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 310,000	$ 273,123			$ 26,751	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	14,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	14,587	2
3. Under or (over) accrual (line 2 minus line 1).	$	87	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	15,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	15,087	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	12,785	8
1999	12,982	9
2000	14,318	10
2001	14,244	11
2002	14,587	12

***Line 7 does not include the Jamestown allocation from page 8 sch VIII $480, Real estate taxes on page 4 line 33 should reconcile to line 7 $15087 + Jamestown $480 = $15567.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIRVIEW NURSING CENTER COUNTY PERRY

FACILITY IDPH LICENSE NUMBER 0024992

CONTACT PERSON REGARDING THIS REPORT ROGER W. BAGLEY

TELEPHONE (618) 549-8331 FAX #: (618) 549-0133

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1-61-0270-100	sec 17 twp 06 rng01 s sw sw ne e 215'	$ 14,587.00	$ 14,587.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 14,587.00	$ 14,587.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,640 B. General Construction Type: Exterior brick Frame wood & concrete Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING	76,230	1968	$ 3,996	1
2					2
3	TOTALS	76,230		$ 3,996	3

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1968	1968	$ 94,863	$	40	$ 2,372	$ 2,372	$ 84,719	4
5			1968	1968	61,381		20			61,381	5
6			1970	1970	3,953		20			3,953	6
7	18		1970	1970	26,047		38	685	685	23,119	7
8	16		1976	1976	177,922		30	5,931	5,931	164,586	8
	Improvement Type**										
9	FIRE ALARM			1981	1,190		10			1,190	9
10	SEWER LINE			1982	1,056		10			1,056	10
11	PLUMBING IMPROVEMENTS			1984	1,193		10			1,193	11
12	ROOF & LANDSCAPING			1984	1,488		10			1,488	12
13	ACTIVITY ROOM			1986	15,306		20	765	765	13,579	13
14	ACTIVITY ROOM			1987	5,223		20	261	261	4,502	14
15	ROOF & LANDSCAPING			1987	9,775		10			9,775	15
16	PARKING LOT			1987	18,960		15			18,960	16
17	SECURITY SYSTEM			1988	2,583		15	89	89	2,583	17
18	RENOVATIONS			1989	2,723		15	175	175	2,723	18
19	HOT WATER HEATER			1990	4,128		15	275	275	3,713	19
20	6 WALL A/C UNITS			1990	7,205		8			7,205	20
21	LANDSCAPING			1990	495		10			495	21
22	SHOWERS/CUBICLE TRACKS			1990	8,459	119	15	564	445	7,614	22
23	ROOF			1990	13,831	439	25	553	114	7,466	23
24	TELEPHONE			1991	3,274		20	164	164	2,050	24
25	WATER HEATER			1991	1,945		15	130	130	1,625	25
26	EMERGENCY LIGHTS			1992	960		15	64	64	736	26
27	SEAL & STRIPE PARKING LOT			1994	1,421		5			1,421	27
28	EMERGENCY LIGHTS			1995	994		15	99	99	842	28
29	HOT WATER HEATER			1995	7,433		15	496	496	4,216	29
30	SUBPANELS & CIRCUITS INSTALLED TO A/C			1996	2,394	239	10	240	1	1,800	30
31	PT A/C UNIT			1996	1,163	116	10	116		870	31
32	A/C UNIT			1996	1,071	107	10	107		807	32
33	INSTALLED SERVICE CABLE			1997	7,666	511	15	511		3,322	33
34	A/C UNITS			1998	698	62	10	70	8	385	34
35	HOT WATER HEATER			1998	2,985	266	15	199	(67)	1,095	35
36	OVERBED LIGHTING			1998	8,932	797	15	595		3,273	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CARPET	1998	$ 588	$ 52	5	$ 57	$ 5	$ 588	37
38	BASEBOARD HEATING	1998	3,599	321	15	240	(81)	1,320	38
39	CABINETS & COUNTERTOPS	1998	708	63	5	69	6	708	39
40	WALLPAPER & INSTALLATION	1998	9,457	844	5	947	103	9,457	40
41	PAINTING	1998	11,779	1,051	5	1,177	126	11,779	41
42	Trim, pictures, mirrors, permanent decorative fixtures	1998	2,007	179	5	202	23	2,007	42
43	FLOOR COVE BASE	1998	901	80	5	91	11	901	43
44	MORTON STORAGE BUILDING	1998	3,917	124	15	261	137	1,175	44
45	BUILDING ADDITION	1998	239,137		15	15,942	15,942	71,739	45
46	PARKING LOT	1998	13,916		15	928	928	5,104	46
47	FLOORING - ADJUSTMENT TO 1998 BLDG ADDITION	1999	737		5	147	147	662	47
48	DOOR ALARM SYSTEM	1999	6,691		10	669	669	3,011	48
49	WALLPAPER & PAINTING	1999	8,314	1,663	5	1,663		7,483	49
50	INSTALL BOOKCASE IN ADMIN OFFICE	1999	333	67	10	66	(1)	297	50
51	LANDSCAPING	1999	5,931	593	10	593		2,669	51
52	SEAL COATED & STRIPED PARKING LOT	1999	1,646	206	8	206		927	52
53	INSTALL TELEPHONES IN BREAKROOM & DINING	1999	777	155	5	155		698	53
54	MOVE PHONE LINES	1999	328	66	5	67	1	301	54
55	ENTRANCE SIGN	1999	1,000	200	5	200		900	55
56	PAINT WINDOW GRIDS	1999	175	35	5	35		158	56
57	INSTALLATION OF FLOORING	1999	8,949	895	10	895		4,027	57
58	FOUNTAIN AND LIGHT	1999	1,774	355	5	355		1,597	58
59	balance of trim, pictures, mirrors, permanent decorative	1999	3,952	69	5	790	721	3,555	59
60	fixtures to refurbish the building								60
61	AWNINGS	1999	420	38	5	84	46	378	61
62	Labor & materials to remove existing wall & rebuild new	1999	8,559	856	10	856		3,852	62
63	wall, relocate plumbing & electrical services, install								63
64	cabinetry & countertops, and installed new tile flooring								64
65	Labor & materials to gut an existing bathroom and rehab								65
66	room to create 2 new bathrooms, and storage areas for								66
67	housekeeping and dietary (to be completed in 2000).								67
68	Labor & materials to install new cabinets, relocate plumbing								68
69	& electrical, repair drywall & paint the breakroom								69
70	TOTAL (lines 4 thru 69)		$ 834,312	$ 10,568		$ 41,156	$ 30,790	$ 579,035	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 834,312	$ 10,568		$ 41,156	$ 30,588	$ 579,035	1
2	Labor & materials to complete 1999 bathroom project	2000	20,296	2,030	10	2,030		7,105	2
3	Installed ceramic tile, sinks, toilet stool, showers, and								3
4	lighting fixtures.								4
5	Labor & materials to remove existing wall in order to convert	2000	11,212	1,121	10	1,121		3,924	5
6	storage room into a resident room. Removed existing								6
7	closets, installed shower area, relocated doors, electrical,								7
8	and plumbing services, repaired and painted drywall &								8
9	relocated call lights.								9
10	Excavate & replace driveway asphalt & fill in crack with tar.	2001	3,075	205	15	205		513	10
11	Reinforce & raise sinking floor on B wing	2001	7,380	492	15	492		1,230	11
12	Gut beauty shop area and construct a new handicapped	2001	16,165	1,078	15	1,078		2,695	12
13	bathroom. New wiring, plumbing, flooring, shower , toilet								13
14	sink, door, sprinkler heads, cubicle tracks & curtains,								14
15	and cove base								15
16	Sewer repair to 3 bed ward bathroom. Removed concrete	2001	2,800	187	15	187		467	16
17	replaced deteriorated sewer line, install new line, and new								17
18	clean out and pour new floor.								18
19	Relocate beauty shop to PT area. Installed lines, clean out	2001	1,223	82	15	82		205	19
20	& shut off valves, drill & knock out outside brick wall								20
21	install fan, finish drywall, paint, install tile on drywall,								21
22	install sink & shelves								22
23	Convert existing bathroom to handicapped bathroom.	2001	7,124	475	15	475		1,187	23
24	Remove tile, install box for call lights, tear out & reconstruct								24
25	showers, tile walls & showers, install handrails in tub &								25
26	showers, hang tracks & curtains, put new lever handle door								26
27	lever.								27
28	Add fan to isolation room for medicare compliance.	2001	386	26	15	26		65	28
29	Install 2 sprinkler heads in store room & water heater closet	2001	338	23	15	23		57	29
30	Upgrade emergency lighting & moved anunciator panel	2001	15,138	1,514	10	1,514		3,785	30
31	& smoke detectors.								31
32	Upgrade nurses call station	2001	645	65	10	65		162	32
33									33
34	TOTAL (lines 1 thru 33)		$ 920,094	$ 17,866		$ 48,454	$ 30,588	$ 600,430	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 920,094	$ 17,866		$ 48,454	$ 30,588	$ 600,430	1
2	Install grease trap and wet well	2002	13,224	1,322	10	1,322		1,983	2
3	Replaced rusted out main line drain in B hallway and	2002	3,494	349	10	171	(178)	256	3
4	reinstalled drain to connect to mainline in B hall bath								4
5	Removed old flooring and replaced with ceramic tile in	2002	1,706	171	10	349	178	524	5
6	A hall bathroom								6
7	Repair roof over front dining room and activity room	2002	8,230	823	10	823		1,235	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 946,748	$ 20,531		$ 51,119	$ 30,588	$ 604,428	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 105,326	$ 4,472	$ 10,794	$ 6,322	variable	$ 66,295	71
72	Current Year Purchases	1,994	1,994	100	(1,894)	variable	100	72
73	Fully Depreciated Assets	163,849				variable	163,849	73
74								74
75	TOTALS	$ 271,169	$ 6,466	$ 10,894	$ 4,428		$ 230,244	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	JAMESTOWN ALLOCATION			$	$ 2,118	$ 2,118	$		$ 14,563	76
77										77
78										78
79										79
80	TOTALS			$	$ 2,118	$ 2,118	$		$ 14,563	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,221,913	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,115	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 64,131	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 35,016	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 849,235	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	PARKING LOT 1968	$ 3,720	$	$ 3,720	86
87	ROOF 1968	7,440		7,440	87
88	FIRE ALARM 1969	130		130	88
89	EQUIPMENT VAR	24,719		24,719	89
90	Assets no longer in use (obsolete)				90
91	TOTALS	$ 36,009	$	$ 36,009	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: not applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 999 Description: DISH MACHINE (828) STORAGE (171)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

WE ONLY HIRE TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3 & 39/2	hrs	$	203	$ 12,825	$ 113	203	$ 12,938	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		74	5,792		74	5,792	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		337	21,012		337	21,012	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				18,487		18,487	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	med sup, tube feeding oxygen, Other (specify): lab, xray,	39/2 39/3				1,311	11,220		12,531	13
14	TOTAL			$	614	$ 40,940	$ 29,820	614	$ 70,760	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 46,992	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	185,953		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	256,150		5
6	Prepaid Insurance	11,731		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): investment	6,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 506,826	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	153,639		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	385,634		16
17	Accumulated Depreciation (book methods)	(403,483)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 135,790	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 642,616	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 38,324	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,349		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,467		31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401k LIABILITY	8,059		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 100,199	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 100,199	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 542,417	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 642,616	$	48

***(See instructions.)**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 435,417	1
2	Restatements (describe):		2
3	2002 IL REPLACEMENT TAX	(1,529)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 433,888	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	121,898	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) EXCESS SALARIES ELIMINATED	(13,369)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 108,529	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 542,417	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,794,593	1
2	Discounts and Allowances for all Levels	37,042	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,831,635	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	85,400	6
7	Oxygen	2,643	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 88,043	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	673	19
20	Radiology and X-Ray	247	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 920	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	734	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 734	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,921,332	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	391,741	31
32	Health Care	757,603	32
33	General Administration	446,483	33
	B. Capital Expense		
34	Ownership	91,237	34
	C. Ancillary Expense		
35	Special Cost Centers	70,760	35
36	Provider Participation Fee	41,610	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,799,434	40
41	**Income before Income Taxes (line 30 minus line 40)****	121,898	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 121,898	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** **IL Replace tax deduc on federal return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,032	2,080	$ 41,187	$ 19.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,232	2,277	36,763	16.15	3
4	Licensed Practical Nurses	11,321	12,071	163,573	13.55	4
5	Nurse Aides & Orderlies	35,746	37,553	338,205	9.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,569	1,809	23,946	13.24	8
9	Activity Director	2,875	3,038	30,752	10.12	9
10	Activity Assistants					10
11	Social Service Workers	1,869	1,949	21,245	10.90	11
12	Dietician					12
13	Food Service Supervisor	2,104	2,204	22,617	10.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,554	9,047	68,386	7.56	15
16	Dishwashers					16
17	Maintenance Workers	1,898	2,040	21,702	10.64	17
18	Housekeepers	6,396	6,924	62,342	9.00	18
19	Laundry	3,961	4,268	44,689	10.47	19
20	Administrator	1,904	2,080	52,202	25.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,956	2,080	22,756	10.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	84,417	89,420	$ 950,365 *	$ 10.63	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	120	$ 5,918	1/3	35
36	Medical Director		900	9/3	36
37	Medical Records Consultant		200		37
38	Nurse Consultant			10/3	38
39	Pharmacist Consultant		420	10/3	39
40	Physical Therapy Consultant	53	3,119	10A/3	40
41	Occupational Therapy Consultant	1	54	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	140	10A/3	43
44	Activity Consultant	42	2,160	11/3	44
45	Social Service Consultant	42	2,160	12/3	45
46	Other(specify)				46
47	PURCHASING CONSULTANT		448	19/3	47
48	UTILIZATION REVIEW		900	10/3	48
49	TOTAL (lines 35 - 48)	260	$ 16,419		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 328	10/3	50
51	Licensed Practical Nurses	1,499	43,876	10/3	51
52	Nurse Aides	1,327	24,049	10/3	52
53	TOTAL (lines 50 - 52)	2,834	$ 68,253		53

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAM GARRIS	ADMINISTRATOR	0	$ 52,202
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,202

B. Administrative - Other

Description	Amount
BONUS TO MANAGEMENT COMPANY EMPLOYEES	$ 6,684
TOTAL (agree to Schedule V, line 17, col. 3)	$ 6,684
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MGMT CORP	MANAGEMENT	$ 134,396
MIKRON	COMPUTER SERVICE	1,980
ADP	PAYROLL	570
BARNETT & LEVINE	ACCOUNTING	1,480
M.E.S.	PURCHASING	448
BENEFIT PLANNING CONS.	401k SERVICES	1,288
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 140,162

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,949
Unemployment Compensation Insurance	19,109
FICA Taxes	72,703
Employee Health Insurance	6,510
Employee Meals	1,821
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	10
VACCINES	706
401k EMPLOYER MATCHING	8,202
STAFF PARTIES, ATTENDANCE, AWARDS, E	7,888
JAMESTOWN ALLOCATION	8,475
TOTAL (agree to Schedule V, line 22, col.8)	$ 168,373

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	2,589
Health Care Worker Background Check	240
(Indicate # of checks performed 20)	
OTHER ADV (2135) SUBSCRIP (217)	2,352
IAPA (30) CORP FEES (349)	379
NAGNA (1867)	1,867
CHAMBER OF COMM (100) ELIM 100	0
JAMESTOWN ALLOCATION	180
ELIMINATE ONE YEAR OF IDPH LICEN	(200)
Less: Public Relations Expense	(1,619)
Non-allowable advertising	( )
Yellow page advertising	(516)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,672

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	529
Seminar Expense	2,104
JAMESTOWN ALLOCATION	209
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,842

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FAIRVIEW NURSING CENTER # 0024992 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,610**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,821** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

FAIRVIEW NURSING CENTER INC
RECLASSIFICATIONS ON DPA COST REPORT
12/31/2003

PAGES 3 & 4 COLUMN 5
ID# 0024992

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
2	FOOD PURCHASES	3206	
10	NURSING & MEDICAL RECORDS		3206
	RECLASSIFY FOOD SUPPLEMENTS		
21	CLERICAL & GENERAL OFFICE EXPENSE	699	
10	NURSING & MEDICAL RECORDS		699
	RECLASSIFY OFFICE SUPPLIES		
2	FOOD PURCHASES	2985	
11	ACTIVITIES		2985
	RECLASSIFY FOOD PURCHASED FOR ACTIVITY DEPARTMENT		
10	NURSING & MEDICAL RECORDS	1046	
3	HOUSEKEEPING		1046
	RECLASSIFY SOAP & SHAMPOO		
22	EMPLOYEE BENEFITS	1821	
2	FOOD PURCHASES		1821
	RECLASSIFY EMPLOYEE MEALS		
VARIOUS	VARIOUS LINE ITEMS	81600	
19	PROFESSIONAL SERVICES		81600
	SEE SCHEDULE VIII FOR BREAKDOWN		